DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Children and Family Services
CFS-2001 (Rev. 02/2003)

STATE OF WISCONSIN
Re: Wisconsin Statutes, s. 46.03
P.L. 98-8 (as amended)

PLEASE PRINT

TEFAP ELIGIBILITY CERTIFICATION

Name - Last	First	MI	Telephone Number

Street Address	City	Zip Code	County

I CERTIFY WITH MY SIGNATURE THAT:

- My monthly gross household income is at or below the federally approved DCFS limits for participation in this program for the number of people in my household as indicated on this form.
- I will use the federal commodities received for household consumption only.
- I release the USDA / PNS, the State of Wisconsin and any agency or person distributing federal commodities from any liability resulting from receipt of this food.
- I understand that making a false certification may result in my having to reimburse the State for the value of food improperly issued to me and may subject me to criminal prosecution under State and Federal law.
- Rules for acceptance and participation in the program are the same for everyone without regard to race, color, religion, national origin, age, sex or disability.
- Reasonable accommodations may be requested to participate in this program.

MAXIMUM INCOME FOR RECEIPT OF TEFAP COMMODITIES

Household Size	Monthly Income	Household Size	Monthly Income	Household Size	Monthly Income
1	$1,384	4	$2,837	7	$4,290
2	$1,869	5	$3,321	8	$4,775
3	$2,353	6	$3,805	9	$5,260
				10	$5,745

For each additional household member over ten add $485 monthly.

	DATE	RECIPIENT SIGNATURE	FAMILY SIZE ADULTS	FAMILY SIZE CHILDREN	ADDRESS VERIFIED YES	ADDRESS VERIFIED NO	DO YOU NEED OTHER ASSISTANCE YES	DO YOU NEED OTHER ASSISTANCE NO	TYPE OF OTHER PROGRAM INFORMATION GIVEN TO CLIENT
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									

Name - Pantry	Address - Pantry

Name - Emergency Feeding Organization	Date Form Filled Out